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**STATE OF WISCONSIN**  
**Division of Hearings and Appeals**

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In the Matter of

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

DECISION

MPA/171359

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**PRELIMINARY RECITALS**

Pursuant to a petition filed January 11, 2016, under Wis. Stat. § 49.45(5), and Wis. Admin. Code § HA 3.03(1), to review a decision by the Division of Health Care Access and Accountability in regard to Medical Assistance, a hearing was held on February 04, 2016, at Milwaukee, Wisconsin.

The issue for determination is whether the Department of Health Services, Division of Health Care Access and Accountability (DHS) correctly denied a request from [REDACTED] ([REDACTED]) to provide 70 hours per week of Private Duty Nursing (PDN) services to the Petitioner.

There appeared at that time and place the following persons:

**PARTIES IN INTEREST:**

Petitioner:

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

[REDACTED]

Respondent:

Department of Health Services  
1 West Wilson Street, Room 651  
Madison, Wisconsin 53703

By: [REDACTED], RN Consultant  
Division of Health Care Access and Accountability  
1 West Wilson Street, Room 272  
P.O. Box 309  
Madison, WI 53707-0309

**ADMINISTRATIVE LAW JUDGE:**

Mayumi M. Ishii  
Division of Hearings and Appeals

**FINDINGS OF FACT**

1. Petitioner is a resident of Milwaukee County.

2. On November 13, 2015, [REDACTED] submitted on behalf of Petitioner, a request for prior authorization of 70 hours per week of PDN services for 52 weeks, at a cost of \$364,000. (Exhibit 4, pg. 5)
3. According to the orders in the Care Plan Attachment the RN is to perform the following tasks:
  1. Assess temperature, pulse, respiration (including oxygen saturation checks) and blood pressure as needed.
  2. Weigh patient weekly
  3. Conduct Pulmonary assessment at the beginning of the day ( frequency not stated)
  4. Conduct Neuromuscular assessment (frequency not stated)
  5. Genitourinary assessment (frequency not stated)
  6. Gastrointestinal assessment (frequency not stated, but child is tube fed)
  7. Pain assessment daily and as needed
  8. Cardiac assessment (frequency not stated)
  9. Respiratory assessment, every shift and as needed.

(Exhibit 4, pgs. 11 and 12)
4. On December 8, 2015, DHS sent notices to the Petitioner and to [REDACTED] indicating that [REDACTED]'s request for prior authorization was denied. (Exhibit 4, pgs. 24-28)
5. The Petitioner is a six year old child that is fed via g-tube. He has a history of dysphagia, vision abnormalities, epilepsy, and infantile spasms - secondary to post craniotomy for seizure hemispherectomy. He also suffers from developmental delays. (Exhibit 4, pgs. 18-19)
6. Petitioner has also been noted to have hemiplegia. (Exhibit 3, attachment 11)

### **DISCUSSION**

When determining whether to approve therapy, the Medicaid program must consider the generic prior authorization review criteria listed at *Wis. Admin. Code, §DHS 107.02(3)(e)*:

(e) *Departmental review criteria.* In determining whether to approve or disapprove a request for prior authorization, the department shall consider:

1. The medical necessity of the service;
2. The appropriateness of the service;
3. The cost of the service;
4. The frequency of furnishing the service;
5. The quality and timeliness of the service;
6. The extent to which less expensive alternative services are available;
7. The effective and appropriate use of available services;
8. The misutilization practices of providers and recipients;
9. The limitations imposed by pertinent federal or state statutes, rules, regulations or interpretations, including medicare, or private insurance guidelines;
10. The need to ensure that there is closer professional scrutiny for care which is of unacceptable quality;
11. The flagrant or continuing disregard of established state and federal policies, standards, fees or procedures; and
12. The professional acceptability of unproven or experimental care, as determined by consultants to the department.

“Medically necessary” means a medical assistance service under ch. DHS 107 that is:

- (a) Required to prevent, identify or treat a recipient's illness, injury or disability; and
- (b) Meets the following standards:
1. Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;
  2. Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider, and the setting in which the service is provided;
  3. Is appropriate with regard to generally accepted standards of medical practice;
  4. Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient;
  5. Is of proven medical value or usefulness and, consistent with s. DHS 107.035, is not experimental in nature;
  6. Is not duplicative with respect to other services being provided to the recipient;
  7. Is not solely for the convenience of the recipient, the recipient's family, or a provider;
  8. With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and
  9. Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

*Wis. Admin. Code, §DHS 101.03(96m).*

As with most public assistance benefits the initial burden of demonstrating eligibility for any particular benefit or program at the operational stage falls on the applicant, *Gonwa v. Department of Health and Family Services*, 2003 WI App 152, 265 Wis.2d 913, 668 N.W.2d 122 (Ct.App.2003). In other words, it is a Petitioner's burden to prove, by a preponderance of the credible evidence, that he qualifies for the requested services. It is not the Department's burden to prove that s/he is not eligible.

Further, I note that Medicaid is meant to provide the most basic and necessary health care services at a reasonable cost to a large number of persons and must authorize services according to the Wisconsin Administrative Code definition of medical necessity and other review criteria noted above. It is not enough to demonstrate a benefit; rather, all of the tests cited above must be met.

In order to receive Medicaid payment for private duty nursing services an individual must require skilled nursing interventions for at least eight hours per day. See Wisconsin Administrative Code, §DHS 107.11 and 107.12. All private duty nursing requests require prior authorization for Wisconsin Medicaid payment. See Wisconsin Administrative Code, §DHS 107.12 (2)(a).

Direction as to how to calculate hours of nursing care required comes from the Department's provider Handbook:

To determine if a member receives eight or more hours of direct skilled nursing services, **add up the total hours of direct skilled nursing care provided by all caregivers, including home health agencies, independent nurses, and skilled cares provided by family or friends.** If the total time required daily for these cares is equivalent to eight or more hours, the member is eligible for PDN. The POC is required to include the actual amount of time to be spent on medically necessary direct cares that require the skills of a licensed nurse.

For this purpose, Medicaid-covered skilled nursing services may include, but are not limited to, the following:

- Injections.
- Intravenous feedings.
- Gastrostomy feedings (include the time needed to begin, disconnect, and flush — not the entire time the feeding is dispensing).
- Nasopharyngeal and tracheostomy suctioning.
- Insertion and sterile irrigation of catheters.
- Application of dressings involving prescription medications and aseptic techniques.

- Treatment of extensive decubitus ulcers or other widespread skin disorders.

See:

<https://www.forwardhealth.wi.gov/WIPortal/Online%20Handbooks/Display/tabid/152/Default.aspx?ia=1&p=1&sa=29&s=2&c=365>

According to the orders in the Care Plan Attachment, the RN is to perform the following tasks:

1. Assess temperature, pulse, respiration (including oxygen saturation checks) and blood pressure as needed.
2. Weigh patient weekly
3. Conduct Pulmonary assessment at the beginning of the day ( frequency not stated)
4. Conduct Neuromuscular assessment (frequency not stated)
5. Genitourinary assessment (frequency not stated)
6. Gastrointestinal assessment (frequency not stated, but child is tube fed)
7. Pain assessment daily and as needed
8. Cardiac assessment (frequency not stated)
9. Respiratory assessment, every shift and as needed.

Looking at the nine tasks listed on the plan of care, the only task included on the list of skilled nursing services covered by Medicaid, are the g-tube feedings, which Petitioner's nurse indicated should be monitored by an RN due to his risk of silent aspiration. It is not clear from the record why the skills of a registered nurse are required to complete the other listed assessments. Further, since the frequency of five of nine tasks, including the g-tube feeding, is not listed, it is difficult to calculate how much time is needed to complete those tasks.

Based upon the foregoing, it is found that [REDACTED] ( [REDACTED] ) has not demonstrated that the Petitioner needs eight or more hours per day of skilled nursing services.

[REDACTED], one of the Petitioner's nurses, testified that the Petitioner has daily seizures that would go unnoticed by an untrained individual. However, [REDACTED] also testified that neither she, nor anyone else from [REDACTED] kept a seizure log, nor did they keep any copies of the notes they passed on to Petitioner's mother, that might document the frequency, duration and severity of the seizures. This is particularly problematic, since Petitioner's medical records indicate that he has been clinically seizure free since January 2015. (Exhibit 3, attachment 8; see also Exhibit 3, attachment 11)

It is clear that the Petitioner has a complex medical condition and requires monitoring. However, the prior authorization request submitted by [REDACTED] lacks sufficient clarity with regard to the tasks to be performed and the frequency/time required to complete those tasks. It also lacks sufficient medical documentation to justify the need for 10 hours per day, 70 hours per week of skilled nursing services.

Petitioner's mother should note that [REDACTED] can, at any time, submit a new request for prior authorization that includes the necessary documentation.

### **CONCLUSIONS OF LAW**

DHS correctly denied a request from [REDACTED] ( [REDACTED] ) to provide 70 hours per week of Private Duty Nursing (PDN) services to the Petitioner.

**THEREFORE, it is**

**ORDERED**

That the petition is dismissed.

**REQUEST FOR A REHEARING**

You may request a rehearing if you think this decision is based on a serious mistake in the facts or the law or if you have found new evidence that would change the decision. Your request must be **received within 20 days after the date of this decision**. Late requests cannot be granted.

Send your request for rehearing in writing to the Division of Hearings and Appeals, 5005 University Avenue, Suite 201, Madison, WI 53705-5400 **and** to those identified in this decision as "PARTIES IN INTEREST." Your rehearing request must explain what mistake the Administrative Law Judge made and why it is important or you must describe your new evidence and explain why you did not have it at your first hearing. If your request does not explain these things, it will be denied.

The process for requesting a rehearing may be found at Wis. Stat. § 227.49. A copy of the statutes may be found online or at your local library or courthouse.

**APPEAL TO COURT**

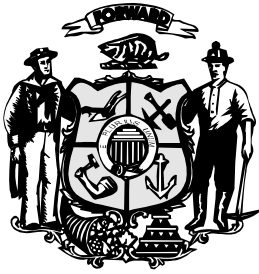
You may also appeal this decision to Circuit Court in the county where you live. Appeals must be filed with the Court **and** served either personally or by certified mail on the Secretary of the Department of Health Services, 1 West Wilson Street, Room 651, Madison, Wisconsin 53703, **and** on those identified in this decision as "PARTIES IN INTEREST" **no more than 30 days after the date of this decision** or 30 days after a denial of a timely rehearing (if you request one).

The process for Circuit Court Appeals may be found at Wis. Stat. §§ 227.52 and 227.53. A copy of the statutes may be found online or at your local library or courthouse.

Given under my hand at the City of Milwaukee,  
Wisconsin, this 24th day of March, 2016.

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\sMayumi M. Ishii  
Administrative Law Judge  
Division of Hearings and Appeals



**State of Wisconsin\DIVISION OF HEARINGS AND APPEALS**

Brian Hayes, Administrator  
Suite 201  
5005 University Avenue  
Madison, WI 53705-5400

Telephone: (608) 266-3096  
FAX: (608) 264-9885  
email: [DHAmail@wisconsin.gov](mailto:DHAmail@wisconsin.gov)  
Internet: <http://dha.state.wi.us>

The preceding decision was sent to the following parties on March 24, 2016.

Division of Health Care Access and Accountability